Legislative Services Agency

MINUTES

Nursing Staff in Hospitals Study Committee

October 18, 2005

MEMBERS PRESENT:

Senator Joe Bolkcom, Co-chairperson
Senator James Seymour, Co-chairperson
Senator Dave Mulder
Senator Amanda Ragan
Representative Linda Upmeyer, Co-chairperson
Representative Walt Tomenga
Representative Beth Wessel-Kroeschell

MEETING IN BRIEF

Organizational staffing provided by: Richard Nelson, Senior Legal Counsel, (515) 242-5822

Minutes prepared by: Kathy Hanlon, Senior Research Analyst, (515) 281-3847

I. Procedural Business.

Call to Order. The first meeting of the Nursing Staff in Hospitals Study Committee was called to order by temporary Co-chairperson Seymour at 10:03 a.m., Tuesday, October 18, 2005, in Room 116 of the State Capitol Building in Des Moines, Iowa.

Preliminary Business. Temporary Co-chairperson Bolkcom reviewed Senate Resolution 23, which initiated the Committee's formation. The resolution requested the Legislative Council to authorize an interim study committee to review the nurse staffing needs of Iowa's hospitals and to make recommendations for options to improve hospital nurse staffing levels. The resolution, as introduced, states that research indicates that hospitals with low nurse staffing levels tend to have higher rates of poor patient outcomes, that there is a persistent shortage in the number of qualified nurses in Iowa's hospitals, that the acuity level (a categorization process for accurately documenting patient comorbidities and complications used to determine the level of medical care required) of patients in hospitals is increasing, that the average length of patient stay is decreasing, and that the use of medical technologies has led to increases in the amount of care required while in a hospital.

Senator Ragan moved the permanent election of Temporary Co-chairpersons Bolkcom, Seymour, and Upmeyer. Senator Mulder seconded the motion, which was unanimously approved on a voice vote. The members also unanimously approved rules governing the Committee by voice vote.

Adjournment. The meeting recessed for lunch at noon, reconvened at 1:02 p.m., and adjourned at 3:30 p.m.

Conference Call/Recommendations. The Co-chairpersons, finding limited consensus among the members on the key issues presented during the meeting, recommended that members adjourn for the day without making recommendations, but consider the information provided during the meeting and be prepared to participate in a future conference call to determine Committee recommendations, which will be based upon concerns shared and agreed upon by the Committee.

II. Nurse Staffing Experience in California/Minimum Nurse-to-Patient Ratios.

A. Opposition.

Overview. Ms. Dorel Harms, MS, RN, FACHE, Vice President of Professional Services for the California Hospital Association; Mr. Greg Boattenhamer, Senior Vice President of Government Relations for the Iowa Hospital Association (IHA); and Ms. Kathy Ripple, Administrative Director of Quality Management, Home Healthcare, and the Visiting Nurse Association at Finley Hospital in Dubuque, who also represents all affiliate hospitals of Iowa Health System, expressed various rationales for opposition to nurse-to-patient ratios.

California Experience. Ms. Harms provided a history of the introduction and implementation of nurse-to-patient ratios in California. She observed that the concept of nurse-to-patient ratios was first used for purposes of intensive care units and well-baby programs in 1976. Ratio legislation was first introduced in 1993, and ratio-mandating ballot initiatives were defeated in 1995. Ratio legislation was signed by Governor Gray Davis in 1999. The complicated nature of the ratio system delayed the development and establishment of regulations until 2003, and delayed full implementation of nurse-to-patient ratios until 2004. Governor Davis advised that the regulations resulting from the enactment of the legislation should be written "so that the minimum required staffing does not exceed that necessary to comply with other existing standards and the levels necessary to provide quality care . . . the minimums should be just that, in order for hospitals to retain reasonable flexibility."

Supporters of the ratios assumed that the supply of nurses would increase, but, she said, that has not happened. California ranks 49th in the nation in RNs to population. The state has not provided funding to implement the ratios, but California hospitals are spending over $50 million per year. The costs for all of California's hospitals to comply with the law is $1 billion per year. The law requires that a nurse of equal competence must take over, at all times, for a nurse who goes on break, which results in the addition of one nurse equivalent for every four nurses employed. Fewer than one in nine hospitals are in compliance with the law, and none are in compliance every hour of the day.

According to Ms. Harms, the law has resulted in surgeries being postponed, ambulances driving greater distances to find a hospital able to take their patients, a worsening of the nursing shortage, a lack of autonomy for nurses, conflicts with other existing laws and regulations, such as the federal Emergency Medical Treatment and Active Labor Act (EMTALA), fear of litigation because a hospital may be sued for adult abuse if it cannot meet the ratios, unfair competition, and a call for changes in the ratios by the California Medical Association. Ms. Harms reviewed the history of litigation related to ratios filed since the law was enacted.

Iowa Hospital Association. Mr. Boattenhamer noted that the IHA opposes bills addressing mandated staff ratios and overtime restrictions in hospitals because such legislation is unnecessary in Iowa. Iowa provides the sixth highest quality care of any state in the nation. Of the 70,000 hospital employees represented by the IHA, one-third are nurses. Staffing ratios do not recognize the daily changes in patient care needs or that hospitals of differing sizes have differing staff needs, and do not address the competency of the nursing staff. He suggested that financial incentive packages for nurses are a more realistic means of addressing staff shortages. Data gathered by the IHA indicates that there are more than 1,000 nurse vacancies in Iowa's hospitals. Extraordinarily low Medicare and Medicaid reimbursement makes it hard for Iowa's hospitals to compete for nurses, and smaller hospitals face the greatest difficulty because they are less able to provide competitive salaries.

Mr. Boattenhamer expressed concern that if a hospital were to staff beyond mandated ratios, large insurers would likely identify the hospital as being overstaffed or inefficient. Mandatory overtime is not being imposed by Iowa's hospitals, though the hospitals must retain the flexibility to staff as patient acuity demands. Fear of litigation prevents hospitals from understaffing. He urged the Committee to reject any support of unnecessary staff ratio mandates or overtime restrictions upon Iowa's hospitals and to support measures to enhance Iowa's nursing profession, such as creating more support for nursing faculty and enhanced Medicaid payments to allow for more competitive salaries.

Nurse Administrator. Ms. Ripple noted that the hospitals and associations she represents oppose limits on mandatory overtime because these limits will not improve patient care. Mandatory overtime is a measure of last resort, limited to crisis situations. The many nurses who work part-time or full-time at less than 40 hours per week are often available and willing to work overtime when needed. She listed a number of alternatives to mandatory overtime that hospitals may utilize, including offers of substantial financial incentives to ensure adequate staffing. When those measures are unsuccessful, it is imperative that hospitals have mandatory overtime as an option. She identified situations, such as the need to stay with a surgical case, when it is necessary for a nurse to work the standard shift.

Flexibility to adjust staffing levels was also cited as a reason to oppose minimum nurse-to-patient ratios. Adequate staffing requires a hospital to consider many factors, which are not taken into consideration by arbitrary minimum staffing ratios. Minimum ratios will stress the system further and may create a greater public safety risk. The consequences of implementing ratios include increased emergency room diversions, bed closures, reduced patient access, cutbacks, increased waiting times, and severe negative financial consequences for acute care hospitals that could result in hospital closure. She proposed that policymakers, educators, and providers work together to ensure an adequate supply of nurses, and to increase funding for Medicare and Medicaid reimbursement in Iowa.

B. General Support.

California Experience. Dr. Beth Capell, PhD, of Capell and Associates, California, spoke in support of patient-to-nurse ratios. She noted that California has 30 years of experience with staffing ratios in its operating rooms and intensive care units. Acuity systems or patient classification systems are inadequate to ensure adequate patient care. One-half of emergency room nurses surveyed indicated that they did not have time to properly assess patients. Staffing decisions are often driven by economics, not by what is best for patient care.

When developing the ratios implemented in California, among the factors considered were professional units, region, whether a facility is operated on a profit or not-for-profit basis, and whether a facility is private or public. The assumptions used by the Department of Health Services (DHS) resulted in an overestimation of the number of additional full-time equivalent positions that would be needed with the law's implementation. Using another set of

assumptions cut the estimate by half and the estimated cost to between 0.5 and 1 percent of revenue.

California only educates one-half as many nurses as are needed. California's nursing shortage was substantially worsened by the elimination of premium pay, real wage cuts of 15 to 20 percent, and the expansion of job options. DHS found the staffing at rural hospitals to be richer because of the environment. Rural hospitals are more likely to be in compliance, while large urban for-profit hospitals are the least likely to be in compliance. Hospitals have not closed as a result of the implementation of ratios. Hospitals that have closed were financially ailing for years, or were closed by a large hospital system when the facility did not fit the system's business plan or when that facility competed with other hospitals in the same system.

Ratios are also not to blame if ambulances have to travel farther to find hospitals able to take their patients as California has had a long-standing lack of emergency room capacity. Hospitals have been slow to implement ratios because of hopes that the California Hospital Association lawsuit to change the Department of Health Service's interpretation of the law would be successful.

- **Iowa Union Local.** Ms. Cathy Singer-Glasson, RN, President of Service Employees International Union (SEIU) Local 199 (Iowa), and Chairperson of the SEIU Nurse Alliance, stated that the nursing shortage is a looming crisis as acute care nurses are leaving and few are coming into the profession to replace them. Demand for nurses will grow by 40 percent between 2002 and 2020, while supply is expected to increase by only 6 percent. The situation is having a negative impact on patient care, but too many nurses are afraid to speak out on behalf of patients. A study published by the Journal of the American Medical Association on October 23, 2002, titled "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction" found that for every additional patient a nurse cares for, the mortality rate increases by 7 percent. A May 2002 study published in the New England Journal of Medicine concluded that nurse staffing levels are directly linked to patient outcomes. Nurse staffing has been proven to be cost-effective — a ratio of 1:4 is more cost-effective than 1:8. Bedside nurses attended both forums held by the Iowa Department of Public Health (IDPH), but the forums were not well-attended by direct care nurses. Those direct care nurses who did attend were so intimidated by the large number of nurse administrators and managers from their hospitals who were in attendance that they did not testify. Ms. Singer-Glasson asked that the Committee recommend, and the General Assembly enact, whistleblower protection legislation.
- Ms. Sarah Swisher, RN, Policy Director, SEIU Local 199, remarked that the atmosphere at the University of Iowa Hospitals and Clinics (UIHC) is collegial and promotes staff nurse management. She noted that the SEIU often partners with the IHA on issues such as needle-stick safety. Hospital costs increase if hospitals ignore nurse burnout. The focus should not be on ratios, but on the ability to provide bedside care to

patients. Inadequate staffing can have a negative effect on patient health. Iowa is last in the nation in nurse pay, while health care CEOs in Iowa are paid well.

- Ms. Ann Gentil-Archer, RN, SEIU Local 199 Representative, observed that there is very little oversight on staffing issues for Iowa hospitals. Improving the environment for nurses and allowing nurses to have a voice improves patient outcomes. The recruitment and retention of qualified nurses and the promotion of hospital environments that allow nurses to provide quality and safe patient care are SEIU priorities. Staffing committees at UIHC and Finley Hospital in Dubuque provide nurses with an effective voice in quality patient care. The labor-management committees provide a safe place for nurses and nursing management to comment on quality patient care issues. The committees have developed a form by which nurses may report staffing concerns and inadequate patient care. A written response is provided by nurse management prescribing steps to prevent future problems. Ratios are already being used by hospitals, but they do not consider patient acuity. The IDPH forums made apparent that nursing management was concerned about the nursing shortage, but had no concerns regarding the quality of care in their institutions, while the few bedside nurses who spoke were frustrated by not being allowed to provide quality care. Nurses represented by the SEIU spoke freely at the forums because the union provides whistleblower protection. Those without such protection are afraid to speak up for fear of losing their jobs. All nurses need such protection.

Acuity Scales. Ms. Karen Leigh, RN, spoke in favor of the several acuity scales used by hospitals to determine their staffing needs, but observed that when a budget crunch hits, the scales are not adhered to and hospitals will require that nurses be utilized 110 percent or more, which is physically impossible, leading to unfinished work and unmet patient needs. Such demands lead to nurse burnout and nurses leaving the profession. Potential nurses are repelled by such unrealistic expectations. To attract and retain good nurses, nurses must be protected and reasonable wages and tolerable working conditions must be offered.

III. Nursing Organization Environment in Iowa.

Nurse Staffing Principles. Ms. Karol Joenks, RNC, BSN, President of the Iowa Nurses Association (INA); accompanied by Ms. Linda Goeldner, CHE, CAE, Executive Director of the INA, provided an overview of various organizations representing nurses in the state. Ms. Mary Ann Osborn, RN, Vice President and Chief Clinical Officer at St. Luke's Hospital in Cedar Rapids and 2005 President of the Iowa Organization of Nurse Leaders (IONL), and Ms. Joenks reviewed the IONL/INA Position Statement on Principles for Determining Nurse Staffing which was adopted on July 18, 2005.

The principles state that appropriate nurse staffing can only be achieved through a decision-making process in which nurses evaluate and respond to the patient care needs and outcomes, while authority and accountability for all nurse staffing decisions must rest with the nurse executive working in collaboration with the clinical direct care professionals in each specialty. Mechanisms must be in place to increase or decrease staffing as daily changes in care requirements dictate. The nursing standards for appropriate staffing developed by

nationally recognized nursing associations must be considered. Continuous pursuit of best practices is the obligation of the profession. Ms. Joenks listed the key drivers of intensity of patient care requirements and of the capacity of nursing organizations to provide patient care, which focus on patient care requirements, the experience and expertise of nurses, and the environment in which nurses operate, and the support systems available to the nurses.

Hospital Practices. Ms. Osborn noted that approximately 60 percent of Iowa's nurses work in hospital settings. She identified examples of shared governance and shared decision making practiced in Iowa, including staff self-scheduling, a color-coded method by which nurses may determine and communicate a department's ability to accept additional patients, the provision of additional support-to-unit staff, and peer interviewing of new hires. She expressed concern that mandatory ratios might cause hospitals to reallocate additional resources (such as admission nurses, rapid response teams, wound care teams, and IV therapy nurses) to direct bedside care, causing patients to lose access to specialized expertise and clinicians to lose these resources.

Hospitals respond to unexpected increased staffing needs commonly by calling in nonscheduled or part-time staff, rescheduling a full-time person (i.e., trading a Thursday shift for a Tuesday shift), having managers and supervisors assume a clinical assignment, and moving patients to another department better able to handle the flow. Mandatory overtime is rare and reserved for critical staffing. Nurses must be engaged in the process. IONL opposes mandatory staffing ratios and supports participative decision making and creating positive work environments for professionals.

IV. Public Hearings on Nursing Summary Report.

Overview. Ms. Eileen Gloor, RN, MSN, Executive Director of the Center for Health Workforce Planning, Bureau of Health Care Access, IDPH, summarized the results of three public hearings held in September 2005 to seek input on issues of nurse staff shortages and the use of mandatory overtime in response to the Governor's Task Force on the Nursing Shortage's recommendations. Over 400 written comments were submitted and approximately 277 people attended the hearings, including nurses who provide direct care to patients, nurse executives, nurse managers and supervisors, hospital and college administrators, nurse educators, nursing students, and retired nurses.

Common Concerns. Several common concerns were identified, including the following: maintaining safe, high-quality patient care as the highest priority; low reimbursement rates in Iowa despite high-quality care; a call for shared governance among staff nurses, managers, and administrators; impact of the national nursing shortage in Iowa; and impact of budget cuts on bedside nurses.

Differing Opinions. Though common concerns were identified, participants differed in presenting methods to resolve workplace issues that impact nurses, with the greatest difference between those seeking to set nurse-to-patient ratios into law and those who

oppose such legislation. The majority of those submitting oral comments opposed government intervention in the regulation of nursing staffing and/or overtime as a strategy to relieve nursing shortages and improve quality patient care, while the majority of those who submitted written comments stated a 1:4 ratio would improve staffing in some instances. The dichotomy between oral and written comments highlights a concern expressed by presenters during the meeting, that many nurses do not make their concerns public for fear of retaliation. The overwhelming majority of individuals who submitted written comments requested that their names and institutions' identities be withheld.

Opposition to Ratios. Those who oppose the legislation focused on four topics or beliefs: surveys of Iowa hospitals indicate shared leadership and governance are valued and widespread; establishing ratios that potentially result in denying care due to inadequate staffing places Iowa's hospitals at risk for noncompliance with existing federal legislation (EMTALA); Iowa hospitals and other health facilities are already heavily regulated and additional regulation will increase human resource and financial burdens; and research demonstrates that reducing nurse-to-patient ratios requires an increase in total nurse working hours in an already tight labor market, with substantial wage pressure the likely outcome.

Support for Ratios. Of the 278 who submitted written comments, 180 stated that ratios would make staffing their unit better, and 117 said the lack of funding for Medicaid has impacted their patients. Those submitting written comments also indicated that if the nurse-to-patient ratio was changed in their units, an inadequate staffing ratio would place patients in life-threatening positions and nurses would work scared when patient needs exceed the capability of qualified hardworking nurses to provide safe care, nurse-to-patient ratios are not the sole solution to assuring safe care, and while ratios may improve staffing in some areas, it is important to recognize if ratios change, the skill mix may change as well.

Overtime. Several respondents indicated that overtime hours are not mandated, and described overtime as voluntary and compensated. Others indicated that overtime hours are mandated in their institution despite statements to the contrary. No one supported the use of mandatory overtime hours as a planned staffing strategy, but many stressed the need for flexible staffing when clients exhibit urgent or emergency needs.

Quality Improvement Suggestions. Participants suggested that the General Assembly focus on issues that improve the quality of patient care and patient safety; act to assure nurses receive the education and resources needed to provide safe, quality care to Iowa patients; target efforts to improve Medicare and Medicaid reimbursement rates in Iowa; listen to nurses who provide and manage direct patient care; recognize the complexity of nurse staffing decisions, which should be made by qualified professionals in a milieu of shared governance, at the time and place where care is provided; and address the nursing shortage head-on.

Nursing Shortage Suggestions. Methods proposed for addressing the shortage included building the capacity of Iowa's hospitals and other facilities to improve technology and facility design, increasing funding for nurse education programs and financial aid, increasing funding

for staff development to address a critical need for effective nurse leaders, supporting mentoring programs, allowing older nurses to remain at the bedside, reducing regulatory burdens on hospitals and other health care facilities, standardizing documentation requirements and insurance forms, promoting tax breaks and child care assistance for nurses, improving health and retirement benefits to nurses, increasing funding and supporting programs that prepare middle and high school students for entry into the nursing profession and recruit men and minorities into the nursing field, and providing funding to health care organizations that offer clinical practice settings for nursing students, graduate internships, and customized orientation programs.

V. Demographic Trends in Nursing.

Ms. Lorinda Inman, RN, MSN, Executive Director of the Iowa State Board of Nursing, stated that as of June 30, 2005, 23,175 persons are employed as full-time registered nurses (RNs), with another 8,926 employed part-time. Licensed practical nurses (LPNs) number 5,285 full-time, and 1,843 part-time. However, 39,423 persons are licensed nurses and 10,588 are LPNs. She noted that nearly 9 percent of the RNs surveyed identified themselves as unemployed, while 25.23 percent of the LPNs identified themselves as unemployed. However, the term "unemployed" was not defined in the survey, so, when asked, she could not tell members, during the presentation, how many were actively seeking employment. More than 55 percent practice in acute care settings, 14.36 percent in offices or clinics, 10.35 percent in long-term care, and 7.25 percent in community health. Her presentation identified how many nurses live and work in each county in the state.

VI. University Perspective on Nurse Staffing Issues.

Ms. Linda Everett, RN, PhD, CNAA, BC, Associate Director for the Chief Nursing Office at the UIHC and Director of the Department of Nursing Services and Patient Care at the University of Iowa College of Nursing; and Ms. Linda Chase, RN, MA, CNAA, Senior Assistant Director for the Nursing Administration Department of Nursing Services and Patient Care at the University of Iowa College of Nursing, spoke about nurse staffing from the University of Iowa's perspective:

- **Challenges.** Challenges include assignment in hospitals of appropriate staffing, with an adequate skill mix, covering all shifts, given varied patient acuity needs and a global nursing shortage; availability of resources for staff nurses from other skilled care disciplines; and completion of ongoing education and competencies in a fast-moving, highly technical hospital environment.
- **Recruiting.** To recruit RNs, hospitals must use multiple resources, including costly advertising, although word of mouth is a very successful method, and must continually increase sometimes costly programs, such as babysitting and housecleaning, which may not succeed in their purpose. Hospitals can also work to recruit and retain RNs by creating a culture of safety for all frontline health care providers.

- **Retirements.** The large numbers of RNs retiring by 2008 should not be ignored and efforts should be made to avoid ageism and to utilize these RNs past early retirement age. Older nurses should be recognized as knowledge-workers and valued mentors.
- **Salaries.** Iowa is losing RNs to bordering states because of its noncompetitive salaries. Hospitals should offer increased hourly "bonus" wages for hard-to-staff units.
- **Education.** Educational assistance is necessary, such as college loan forgiveness and tuition reimbursement, but the availability of educational programs must also be increased.
- **Staffing.** Innovative staffing opportunities include weekend option shifts, shifts of varying lengths, flexible schedules, and sculpted staffing.
- **Practice Improvements.** Suggestions for improving nursing practice include use of evidence-based practice to change workflow and utilization of business concepts such as root cause analysis and "Failure Modes and Effects Analysis." Departments of Nursing must measure nursing-sensitive outcomes and be restructured along the Magnet "Blueprint" of 14 Forces, as the program aid in recruitment and retention efforts, because it increases satisfaction with the work environment.

Nursing Faculty Shortage. Ms. Liz Swanson, PhD, RN, Associate Professor at the University of Iowa College of Nursing, addressed the nursing faculty shortage. Student capacity is dramatically limited because of the shortage. Factors in the shortage include budget constraints, an aging faculty, increasing job competition and a lack of preceptors or role models, and masters and doctoral programs that are inadequate to meet the demand. In the past year, only 2 percent of the faculty need was addressed through the hiring of graduates. The American Association of Colleges of Nursing is addressing the shortage by supporting efforts to increase loan and scholarship programs, offering a faculty career online resource for persons considering teaching, developing white papers, and providing a liaison to states to collaborate in grassroots efforts with the states. State-level strategies include giving priority to individuals interested in teaching, loan repayment programs, supporting use in clinical areas of nurses holding a bachelor of science in nursing, creative programs, and the Support 100 Great Nurses Celebration that generates money for scholarships.

VII. Committee Discussion.

The Committee discussed the pros and cons of instituting nurse-to-patient ratios, including the effect of ratios on other health facilities and on levels of nurse burnout. The Committee also discussed the ability of hospitals to financially support ratios. Mr. Boattenhamer was asked to provide data on current nurse staffing levels in Iowa's hospitals. Consideration for the need for whistleblower protection elicited much discussion, including whether such protection is needed, with some arguing that specified statutory provisions and Iowa's Administrative Code provide protection, and others arguing there can be no harm in enacting explicit protection for whistleblowers.

Committee members identified the primary issues emerging from the meeting as mandatory ratios, mandatory overtime, and whistleblower protection. However, because the Committee

lacked consensus on those issues, the Committee agreed that a conference call should be scheduled at a later date, after members have had time to review and consider the information presented. Possible recommendations will be discussed during the conference call.

VIII. Materials Filed With the Legislative Services Agency.

The materials listed were distributed at or in connection with the October 18 meeting and are on file with the Legislative Services Agency. The materials may be accessed from the "Additional Information" link on the Committee's Internet page:

http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=76.

1. Nursing Staff in Hospitals Study Committee Background Information, submitted by Mr. Richard Nelson.
2. Governor Vilsack's Task Force on the Nursing Shortage Final Report, submitted by the Center for Health Care Workforce Shortage, prepared by the Iowa Council of Nurses.
3. Principles for Nurse Staffing, published by the American Nursing Association (ANA) at http://www.nursingworld.org/readroom/stffprnc.htm.
4. An Integrated Analysis of Nurse Staffing and Related Variables: Effects on Patient Outcomes, by Leah L. Curtin, RN, ScD(h), FAAN, published by the ANA at http://www.nursingworld.org/ojin/topic22/tpc22_5.htm.
5. California Ratios: The Ongoing Saga, a Powerpoint presentation provided by Ms. Dorel Harms.
6. Iowa Hospital Association Testimony: Nursing Staff in Hospitals Study Committee, submitted by Mr. Greg Boattenhamer.
7. IHA Legislative Position 2006: Health Care Work Force Issues, submitted by Mr. Boattenhamer.
8. Written testimony of Ms. Kathy Ripple.
9. Written testimony of Ms. Cathy Singer-Glasson.
10. Key Points on Hospital Ratios in California, submitted by Ms. Beth Capell.
11. Written testimony of Ms. Ann Gentil-Archer.
12. Written testimony of Ms. Karen Leigh.
13. Written testimony of Ms. Mary Ann Osborn.
14. Demographic Trends in Nursing, prepared by Ms. Lorinda K. Inman.
15. Nursing Faculty Shortage, prepared by Ms. Liz Swanson.

16. Perspective on Nurse Staffing, prepared by Ms. Linda Everett and Ms. Linda Chase.

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